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REPORT

Substance Use and Gender Based Violence in a Malawian Context – Pilot Project 2

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SINTEF Health Research
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Abstract

This pilot project on Substance use and gender based violence in Malawi is the result of a research collaboration between SINTEF Health Research, Norway and Centre for Social Research, University of Malawi. The study is commissioned by FORUT, Campaign for Development and Solidarity, Norway and NGO Gender Coordination Network, Malawi.

The ***objective*** of this pilot project has been to explore how substance use has an affect on gender based violence in two selected study sites in Malawi. A limited anthropological fieldwork was conducted, and the specific methods used in the study were individual interviews, unstructured conversations and observation. Previous studies from Malawi have shown that women who are married to men who drink alcohol are more exposed to physical abuse in the home. Furthermore, a study has shown that Malawian women are more likely to justify wife beating than men.

The results show that there are three main types of abuse as experienced by the women in this study, namely; economic abuse, physical abuse and sexual abuse. Much of the abuse takes place when the offender has drunk alcohol and/ or smoked chamba. There is a general lack of respect and acknowledgement of women both by men and by women themselves.

This study calls for more research on sexual abuse, alcohol abuse and how this impacts on the spread of HIV/ AIDS in Malawi. Furthermore, the study calls for more attention to the problems connected to alcohol and drug use in Malawi, and its negative affect on wives, families, communities, Malawian society and the country as a whole.

Keywords	English	
Groupe 1	Substance use and abuse	
Groupe 2	Gender based violence	
Selected by auth.	Sexual abuse	

The picture on the front page is taken
during data collection in Malawi in 2007.
Pictured is Miss Ellen Harazi (research assistant)
during an interview with a female informant (anonymous).

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Acknowledgements

This study is the result of a research collaboration between SINTEF Health Research in Norway and the Centre for Social Research (CSR) at the University of Malawi. The author would like to thank the partner from the University of Malawi, Dr. Alister Munthali for his active involvement in the planning of the methodology and in the data collection. The study would not have been the same without his valued input and help.

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I would also like to thank Ms. Emma Kaliya and Mr.Rodgers Neva from NGO Gender Coordination Network in Malawi for their input and stimulating conversations. They helped me to understand better the issues of substance use and abuse in Malawi, and how this affects Malawian women, children and families.

Thanks to Mr. Trevor Chande from the Inter-Ministerial Committee on Drug Control (IMCDC) for introducing me to the policies and legislation concerning substance use and abuse in Malawi.

Last, but not least, I would like to thank FORUT Norway for funding this important and interesting study.

Stine Hellum Braathen
(Project Manager)

1 Introduction

This study on substance use in relation to gender based violence in Malawi is the result of a research collaboration between SINTEF Health Research, Norway and Centre for Social Research, University of Malawi. The study was commissioned by FORUT, Campaign for Development and Solidarity, Norway and NGO Gender Coordination Network, Malawi. The methodology was developed by SINTEF Health Research and Centre for Social Research, as a result of meetings and correspondence between FORUT, NGO Gender Coordination Network, SINTEF Health Research and University of Malawi.

The government of Malawi has in the past few years focused increased attention on drug abuse, through the establishment of an Inter-ministerial Committee on Drug Control (IMCDC), led by the Ministry of Home Affairs and Internal Security. The committee has attempted to identify and quantify the main areas and volumes of cannabis cultivation in Malawi (IMCDC 2004). Furthermore, the Centre for Social Research, University of Malawi, conducted a rapid situation assessment (RSA) of drug abuse and HIV/AIDS in Malawi in 2004 (Bisika et al 2004). The study was commissioned by the Government of Malawi, with funding from the United Nations Office on Drugs and Crime (UNODC). The report states that there is a general lack of central systems for collecting data on drug abuse, and there is no up-to-date prevalence data on drug abuse in Malawi. Data on alcohol use and abuse remains almost inexistent. FORUT has also, through visits and investigations in Malawi, disclosed a general lack of information and research concerning alcohol and drug use and abuse in Malawi. This lack of data means that current policies and programmes related to alcohol and drug abuse have been formulated without a solid basis. Hence, there is a need to develop capacity in Malawi for collecting data on alcohol and drug use and abuse.

This project is intended to be one of the first in a series of research projects to be carried out in Malawi in the field of alcohol, drugs and development, with the ultimate goal of establishing a National Monitoring System for alcohol and drug problems in Malawi. This type of monitoring system is strongly desired by the Malawian authorities and is recommended and encouraged by WHO

Four areas of interest have been identified as focal points in the research strategy:

1. Alcohol and drug use and abuse and its implications (in a broad and exploratory perspective) (Pilot project 1, 2007/2008)
2. ***Alcohol/ drugs and gender based violence (Pilot project 2, 2007/2008)***
3. Alcohol/ drugs and HIV/AIDS
4. Alcohol/ drugs and poverty

This pilot project has had an exploratory design, with the aim of obtaining an overview of the research area. In addition to its inherent value, the results from the pilot project will have added value in relation to further development of broader and more extensive research in the field of alcohol, drugs and social development.

For the purpose of this report the term ***substance use and abuse*** will be used, which includes use and abuse of alcohol and any other psychoactive substances, such as tobacco, cannabis, pills, opiates, inhalants, etc.

The ***objective*** of this pilot project was to explore how substance use has an affect on gender based violence in Malawi; how men's use of substances put women at risk of being violated physically, mentally and sexually.

In addition to these questions, the project will contribute to the knowledge-base on alcohol, drugs and social development in Malawi, as well as feeding into the study design for later, larger studies and nationwide surveys on substance use and abuse in Malawi.

2 Context - Malawi

2.1 The Republic of Malawi

The Republic of Malawi is in southern central Africa, and has a population of around 12.8 million people. On the Human Poverty Index, Malawi is ranked as number 164 of 177 countries, which makes it the 13th poorest country in the world (UNDP 2007/2008). Malawi's economy is predominantly agricultural, and approximately 90% of the population live in rural areas (Loeb & Eide 2004). English and Chichewa are official languages while the literacy rate is 62.7% (76.1% for men, and 49.8% for women) (World Factbook 2008).

Malawi was a British protectorate from 1891 to 1953, known during the latter part of this period as Nyasaland. In 1953 Nyasaland joined a federation with Rhodesia (now Zimbabwe and Zambia), and this federation was dissolved in 1963. In 1964 Malawi became an independent country, with Hastings Banda as president. Banda's presidency soon developed Malawi into a dictatorship. After three decades of this repressive one-party rule, Malawi became a democracy in 1994, with the election of President Bakili Muluzi (from the United Democratic Front; UDF), who presided for ten years. New elections were held in June 2004, with the election of the current president; President Bingu Wa Mutharika. President Mutharika was initially elected as a representative of UDF, but in 2005 he started his own party; Democratic Progressive Party (DPP) (World Factbook 2008).

2.2 Legislation, Institutions, Prevention and Treatment

Malawi has signed various drug control and prevention conventions in the African sub-region and globally, including all the United Nations Drug Control Conventions (The 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances and the 1998 Convention Against Illicit Trafficking of Narcotic and Psychotropic Substances), and the SADC Protocol to combat illicit drug trafficking in the region (Bisika et al 2004).

The Government of Malawi has established an Inter-Ministerial Committee on Drug Control (IMCDC), lead by the Ministry of Home Affairs and Internal Security. The committee is comprised of all Ministries and Departments working in the field of drug control,

and their role is to advise the Government on such issues. The committee has prepared a National Drug Control Master Plan (2005-2009), outlining the direction of Malawi's drug control efforts in the period of 2005-2009. IMCDC has also developed a Drug Control Policy, with its main goal to create a society free from drugs of abuse. Furthermore, the committee has developed a Drug Abuse Bill, which addresses weaknesses in Malawi's current legal framework, and proposes stiffer penalties for drug offences, in line with UN conventions and other protocols in relation to drug production, abuse and trafficking (Bisika et al 2004).

The Malawi Police Force has a unit known as the Dangerous Drugs Section, which was established in 1971 as a very small branch. The unit has, in the past few years, been expanded throughout the country. The police also have drug units at both Lilongwe and Blantyre international airports, but these units are too small to detect any high level drug trafficking (Bisika et al 2004).

Malawi has one major treatment facility for drug abuse at Zomba Mental Hospital, as well as two units with psychiatric beds at one hospital in the north of the country and one hospital in the centre of Malawi. In addition, there are a number of NGOs working in the area of treatment and rehabilitation of drug abusers. These include The Samaritans and Chisomo in Blantyre, Youth Net in Zomba, and St. John of God in Lilongwe (Christian Health Association of Malawi-CHAM) (Bisika et al 2004).

3 Substance Use and Abuse and its Implications in Africa and Malawi

Alcohol is the most widely consumed drug in the world, about half the population above 15 years world-wide have consumed alcohol in the past year. It is difficult to interpret patterns in drinking, because moderate consumption of alcohol is widely accepted in many countries (World Bank 2006). Substances, in particular alcohol, have important cultural and symbolic meanings in many societies. However, alcohol intoxication can lead to a number of temporary impairments in the user and, for many, consumption of alcohol leads to dependence and more permanent impairment. Alcohol consumption plays a major role in morbidity and mortality globally (Babor et al 2003). Across the world, men drink more alcohol than women; they drink more often, and in larger quantities and they cause more problems than women when they drink. Furthermore, surveys in many countries have found that men are much more likely than women to report diagnosable alcohol abuse and dependence (Wilsnack et al 2005).

Alcohol has been present in many societies in the 'developing world' for thousands of years, but the production of alcohol and its social role in these societies is changing. This process of change, which has taken centuries in the so-called Western World, has happened in the 'developing world' over just a few decades (Room et al 2002).

WHO, regional office for Europe, conducted a policy briefing on alcohol and interpersonal violence in 2005 (WHO 2005). The briefing states that alcohol is a major risk factor for all types of injuries, regardless of their intent. Statistics from across Europe shows that alcohol consumption increases the chances of people becoming victims of violence and perpetrators of violence. Men commit most alcohol-related violence.

Child abuse and gender based violence, in particular intimate partner violence, has been linked to alcohol use by men. Women and children who live with men who drink heavily are at much greater risk of experiencing physical violence, and men who have been drinking often inflict more serious violence at the time of the assault. Sexual abuse has also been linked to substance abuse. This can be so because women who drink/ take drugs are at greater risk of being assaulted, and men who drink/ take drugs are more likely to assault (WHO 2002).

For this study and pilot project 1 (see introduction) a ***literature search*** on alcohol, drugs and/ or substance use in Africa in general and Malawi in particular was conducted. In addition, for this study on gender based violence in particular, specific searches on the following keywords were used; violence, abuse, gender based violence and intimate partner violence, in relation to alcohol, drugs and/ or substance use and abuse in Malawi.

The search was done using the databases ScienceDirect, SpringerLink and PubMed, as well as internet sources such as Google and Google Scholar. Some of the literature from Malawi was obtained from local academic and government sources, and cannot therefore be found through the internet or academic databases.

Some literature was found focusing on substance use in the context of war in several African countries. These studies are not directly relevant to the current problems in Malawi, and have therefore been excluded from the literature review below.

The relevant results from the literature search are presented below.

3.1 Substance Use and Abuse in an African Perspective

While there is a general lack of research on the use and abuse of substances in African countries, some relevant studies have been conducted during the past century. A review of the literature on drug use and abuse in Africa (Odejide 2006, p. 102) concludes that *'substance abuse with its ills thrives'* in the developing countries of Africa. People who are poor use substances to feel better and to escape from their otherwise difficult lives, but it only further impoverishes them, and contributes to the destruction of families and societies. In most African countries, young people (age below 15) constitute 40-50 % of the population, and this group is the most vulnerable to substance use and its effects. This leads to a decline in countries' workforce, and the productivity of the nation. Odejide (2006) calls for more focus on substance use and abuse, more resources (human, financial and facilities) to control substance use and more sharing of information on drug abuse across the African continent (Odejide 2006).

A national, representative study among secondary school students in Senegal (Eide et al 2001-2002) showed that the respondents did experiment with alcohol and drugs as in other African countries, but to a lesser extent. It is hypothesised that this trend is caused by the suppression of alcohol in Senegalese

society, which is a muslim society. This study also suggested that increased use of drugs was linked to social status among the study population, ie, the higher the young person's social standing, the more likely they were to use substances. The main drugs used by Senegalese school students are tobacco, alcohol, cannabis and inhalants (Eide et al 2001-2002). Similar results were found among school students in Zimbabwe (Eide 1997), but the reported use of alcohol and tobacco was low compared to corresponding European figures, whereas the use of cannabis and inhalants matched and even exceeded European levels. Again, the use of alcohol and tobacco increased with increasing socio-economic status, while the use of cannabis and inhalants was highest among subgroups with high and low status. Girls reported less experience with drugs than boys (Eide 1997). Apart from the study by Eide (1997) little data concerning alcohol use and abuse in Zimbabwe is available (Jernigan 1999). Jernigan (1999) argues that informed opinion indicates that "*a substantial portion of the population is composed of habitual very heavy drinkers*" (p. 171) and many of Zimbabwe's big problems (HIV, food shortage, droughts, lack of economic growth and investments, etc.) are potentially influenced by alcohol use. There are no restrictions on the promotion of alcoholic products or how alcohol is sold (Jernigan 1999).

A study from Sierra Leone (Bøås & Hatløy 2005) showed that drinking alcohol is not very common, but among those who do drink alcohol, most are single men over 25 years of age. Muslims are less likely to drink alcohol than Christians. People with higher education seem to drink more than those with lower or no education, similarly people drink more alcohol the more they earn. The profile of drug users (mostly marijuana) in Sierra Leone is similar to the profile of alcohol consumers, but the level of use is much lower (Bøås & Hatløy 2005).

In 2003, an international study on Gender, Alcohol and Culture (GENACIS) was conducted in eight countries in Africa, Asia and Latin America. In Africa, Nigeria and Uganda were the two countries selected (Wilsnack et al 2005). The study population in the GENACIS studies were adult men and women aged 18 and above. Data was collected through a set questionnaire, only altered slightly in each country to reflect the local context (Ibanga et al 2005 and Tumwesigye & Kasirye 2005).

The results from Nigeria (Ibanga et al 2005) showed that differences in drinking patterns in Nigeria are determined by factors such as gender, age, income, marital status and area of residence. Males were found to drink proportionately more than women, and drinking by women is generally not accepted in

Nigerian society. Furthermore, men are more likely to drink in bars, at parties, etc., while those women who do drink do so more often at home. Comparing the women who drink to the men who drink, the survey found that these two groups are very similar in their drinking patterns (frequencies, amounts, etc.). The survey also found that those who were single, married or cohabiting tended to drink less than those who were widowed, divorced or separated, and the drinking seemed to increase with age. Among the informants in this survey it was found that those living in a rural area drank more frequently compared to those living in an urban area, and those in the middle-income group reported drinking more than those in the low-income group. The type of alcohol consumed is connected to the status of the consumer, with wine having the 'highest status' of the alcohol types consumed by this study population (Ibanga et al 2005). Similar findings were reported in a study by Gureje et al (2007). Gureje (2007) found that alcohol was the most commonly used substance in Nigeria, followed by sedatives and cannabis.

The results from the GENACIS study in Uganda (Tumwesigye & Kasirye 2005) showed that nearly half of the respondents drank alcohol, but men were more likely to have drunk over a long period of time, more frequent and larger quantities compared to women. Women in the younger generations, however, drank more than women in the older generations, indicting that women's drinking patterns are changing in Uganda. Alcohol is mostly consumed at parties or in bars, and men and women usually drink with other people of the same sex. Factors associated with frequent consumption of alcohol is being male, of older age (30+), being Christian, staying at home and being social. Alcohol consumption was further associated with quarrelling with partner, having more than one sexual partner, physical aggression and smoking, all of which may lead to further financial problems, poor health and loss of relationships (Tumwesigye & Kasirye 2005).

South Africa is one of the countries in Africa where the most research has been conducted on alcohol and drug use. In spite of this, Parry and Bennetts (1999) highlight the need for more monitoring and research as a means of informing policies and for use in the development of drug control plans. Parry and Bennetts (1999) argue that in South Africa alcohol abuse has an enormous negative impact on public health.

A study among high school students (28.3% black, 52.4% coloured and 19.3% white) in Cape Town (Flisher et al 2003) showed that in the previous month 27% had used cigarettes, 31%

alcohol and 7% had used cannabis. Rates were proportionately lower for black females, and the use of substances was associated with the number of days absent from school, the number of years lived in a city and with having to repeat a school grade (Flisher et al 2003). Trends in adolescent alcohol and other drug use in Cape Town, Durban and Gauteng in the period 1997-2001 indicate that there was an increase in the use of alcohol and other drugs in this period (Parry et al 2004). Furthermore, surveys conducted during this period, suggest high levels of alcohol misuse among high school students; alcohol being the most common substance of abuse in this group, followed by cannabis smoked together with methaqualone. These findings are similar to corresponding findings among adolescents globally (Parry et al 2004). Parry et al (2004) highlights the negative consequences associated with adolescent alcohol and drug use and the potential burden it puts on the health, social welfare and criminal justice systems of South Africa.

3.2 Substance Use and Abuse in a Malawian Perspective

There is no systematic, nationally representative data collection on substance use and abuse in Malawi. The Demographic and Health Survey (DHS, last conducted in 2004) has little mention of drugs and alcohol. The Centre for Social Research, University of Malawi, conducted a rapid situation assessment (RSA) of drug abuse and HIV/AIDS in Malawi in 2004 (Bisika et al 2004). The report states that there is a general lack of central systems for collection of drug abuse data, and no up-to-date prevalence data on drug abuse in Malawi.

The RSA was an attempt to collect national data on substance abuse, and its impact on sexually transmitted diseases, more specifically HIV/AIDS. The RSA study found that there are three main drugs of abuse in Malawi; alcohol (both traditional beverages such as Chibuku, Kachasu, and imported beverages like beer), cannabis (known locally as chamba) and tobacco, with the most common drug of abuse being cannabis. Drug abuse is defined in the RSA as ‘the use of any drug of abuse at least on a monthly basis’ (Bisika et al 2004, p. 4). A total of 1218 drug abusers were included in the survey, and of them 96% were male, the majority were single, self employed and young. Compared to the overall population (as described in Malawi DHS, 2000) the drug abusers were five times more educated than the general population. Among the drug abusers, the majority were Protestants (54%) or Catholics (23%), while only 15% were Muslims. The report does

not, however, say anything about the religious divide of the overall population in the study areas.

The report places most of its emphasis on cannabis. Cannabis is grown in most areas of Malawi, and there are increased problems with production, abuse and trafficking. Many reasons for using cannabis were given, such as the price (cheapest form of intoxication), makes one feel better/stronger/more confident/intelligent/happy, improves sexual potency, a traditional cure for measles, etc. The main reason why people in Malawi continue to grow cannabis is poverty. It is relatively cheap to grow and easy to sell for a good profit, compared to other cash crops such as tobacco. With regards to alcohol, the report states that 'alcohol in Malawi is consumed by the general public and is not as stigmatized as cannabis use' (Bisika et al 2004, p. 22).

Methodologically the RSA has some difficulties, as a snowballing method was used to find informants for the survey, and all the informants were defined as drug abusers. This means that the study did not cover a representative sample of the whole population that uses drugs. Furthermore, the study does not say anything about the proportion of the Malawian population that uses drugs, and how much and how often they use it. The report gives important information about the use of chamba in Malawi, but it says very little about the use of various forms of alcohol.

Apart from the study by Bisika et al (2004), a few other studies were found which looked at alcohol and drug use in Malawi (Peltzer 1989/ Carr et al 1994/ Pampel 2005/ MacLachlan et al 1998);

A study looking at causative and intervening factors of harmful alcohol consumption and cannabis use in Malawi was conducted by Peltzer in 1989. The study used qualitative research methods; participant observation and individual interviews, and was conducted over a six-month period. Two urban communities (Blantyre and Mangochi) and one peri-urban (near Zomba) were selected as study sites. The study found no evidence that alcohol consumption and cannabis use was less of a problem in the urban, Muslim community (Mangochi) compared to the urban, Christian community (Blantyre). The socio-economic background of the informants in the two urban communities was similar, while informants from the peri-urban community had substantially less education. The most common form of intoxication was alcohol, followed by cannabis. Cannabis is cheaper than alcohol, and is therefore found to be smoked more often at the end of the work month than just after pay-day. Alcohol consumption, however, was particularly high after pay-day, and people tended to drink more at this time of the month and buy more expensive alcohol (Carlsberg,

Chibuku, etc.) as well. Overall, people living in the urban communities, drank more expensive forms of alcohol compared to those living in the peri-urban communities (Peltzer 1989). The causes of alcohol consumption given were divided into different dimensions. These included the authority dimension (lack of a figure of authority, vague hierarchy in family and feelings of inferiority), the group dimension (bad influence and problems fitting in/coping with peer demands) and the body-mind-environment dimension (unemployment, loss of job, low income, poverty; people drink/smoke to get physical and mental/emotional strength to deal with problems in their lives). Peltzer (1989) discusses possible interventions to reduce alcohol and cannabis use in Malawi. Interventions include; stricter laws (restrictions on the brewing of Kachasu) and more law enforcement, using relatives as good role models, employers making stronger demands on the workers, using peers and partners as good role models and good influence, etc. Interventions should have an impact on the personality and life style of the traditional drinker and Peltzer (1989) argues that 'intervention strategies on a social and community level are no longer effective in the transitional Malawian' (Peltzer 1989, p. 84). He argues that research and interventions should rather be focused on 'the utilization of basic life-style changes observed in some African church settings' (Peltzer 1989, p. 84).

A study (Carr et al 1994) looking at characteristics of chamba users admitted to Zomba mental hospital in Malawi, compared to a control group of patients not admitted because of chamba use, found that the typical chamba patient was 27 years old, male and a subsistence farmer. He used chamba because it was the cheapest form of intoxication, and it made him 'see things clearly' and feel better, but he also experienced feeling confused and paranoid. The long-term effect of chamba was a general feeling of apathy. Furthermore, the chamba user was likely to come from an area in Malawi where chamba is grown, less likely to have been raised by his natural parents, and had more schooling than the control group (Carr et al 1994).

MacLachlan et al (1998) examined the perceptions of the social aspects, triggers and effects of chamba use among 44 male and 10 female psychiatric patients at Zomba mental hospital in Malawi. The data was collected through focus group discussions. They found that chamba is no longer used primarily as a traditional drug (in traditional rites and ceremonies), but it is now used in occupational, medicinal and recreational settings. Seventy five per cent of the respondents believed that chamba use was problematic because of its physiological effects (coughing, sickness, 'sorry

sight', disrupted concentration, impaired mental acuity and 'going mad') and behavioural consequences ('selling the shirt off your back', 'stealing and legal difficulties, familial discord, infidelity', 'it makes you beat up your wife', and 'it makes people drink alcohol to excess') (MacLachlan et al 1998, p. 1369). The other 25% of the respondents, however, did not think that chamba use was a problem, and 100 % of the patients reported having pleasant sensations at the time of chamba intoxication. On the positive side of chamba use, respondents reported feeling happy, strong mentally and physically, less shy, sexually aroused and 'more able to see far away'. These positive feelings made them better at work, gave them courage before addressing an audience, alleviated unpleasant thoughts and feelings, assuaged hunger and made them clever (MacLachlan et al 1998, p. 1370).

A study examining demographic and socioeconomic patterns of tobacco use in Malawi and Zambia in the period 2000-2002 (Pampel 2005), using data from demographic and health surveys in the two countries, found that male tobacco users (aged 15-59) tended to be less educated, urban, in household service or manual workers, divorced and non-religious. Tobacco use was found to be less common among women, but similar characteristics were found among the women and the men who smoke. It was also more common for tobacco users to drink alcohol, and the men who smoked also paid for sex more often. Pampel (2005) concludes that in order to prevent the spread of tobacco use, it is important to focus on disadvantaged groups in the society.

3.3 Gender Based Violence and Substance Use in Malawi

In the Malawian Demographic and Health Survey (DHS), domestic violence was first included as a specific chapter and focus point in the 2004 survey. It is stated that;

> *The inclusion of the domestic violence module (…) is in recognition of the presence of gender-based violence as an economic, human rights, and health issue in Malawi* (Quote Chakwana 2005, p. 265).

The data from the DHS (Chakwana 2005) showed that about one in three women in Malawi had experienced physical violence since the age of 15, and women whose husbands consume alcohol frequently are much more likely to report violence than women whose husbands do not drink (Chakwana 2005).

Pelser et al (2005) conducted a study on intimate partner violence in Malawi in 2005. In the study, they adopted an innovative methodology, where men and women in a household were interviewed simultaneously by male and female researchers respectively. The interview instruments were slightly different in the two interviews; interviews with men focused on attitudes towards women and violence against women, while interviews with women focused on experienced violence as well as attitudes towards the abuse of women. The goal was to get access to the women, to create an arena where they felt free, safe and comfortable to talk. This was done by making the men "busy" with their own interview while their wives or partners were interviewed (Pelser et al 2005). The study was of a quantitative nature, whereby 3546 households were sampled, and within these 3546 females and 2246 males were interviewed. When acts of violence were recorded, the nature of these experiences was explored in more detail through qualitative, open-ended questions.

Physical abuse was the most common form of intra-household gender violence, with 30% of the women reporting some form of physical abuse by a partner, while 25% reported emotional abuse, and just under 18% had experienced sexual abuse. The study found that in 71% of all the households, men were in charge of the household economy, and 28% of the women reported economic abuse, usually through withholding money. Combining all four types of violence, 48% of Malawian women reported some form of intimate partner violence or abuse. Alcohol was commonly associated with acts of *violence*, while there was almost no drug association with violence. In 36% of the reported cases of physical abuse, intoxication was reported. Men's interpretations of the causes of gender based violence were misunderstandings and disagreements (27%), followed by alcohol and chamba (18%), men considering themselves to be superior (8%) and poverty or unemployment (7%). Very few of the violence or abuse cases were reported to the police (Pelser et al 2005).

Rani et al (2004) conducted a study looking at attitudes towards wife-beating among men and women in Benin, Ethiopia, Malawi, Mali, Rwanda, Uganda and Zimbabwe. The study used data from the respective countries' demographic and health surveys (DHS) between 1999 and 2001. In all the countries, men were consistently less likely to justify wife-beating than women, and secondary or higher education and household wealth emerged in

the results as the most significant and consistent predictors of non-acceptance of wife-beating. In Malawi, Muslim men were less likely to justify wife-beating compared to the Catholic respondents. Acceptance of wife-beating in the seven countries was lowest in Malawi, which is also the country in the study with the lowest GDP per capita, and lower female illiteracy rates (24%).

> *The results indicate that dominant social and cultural norms create images of 'ideal' women among both men and women that include definition and widespread acceptance of gender roles as well as sanction use of force to enforce these gender roles. (…) Though education, economic growth, etc. can reduce acceptance of wife-beating, the process may be too slow and too late to make a substantial difference in the near future. Proactive measures may be required to change attitudes towards wife-beating among both men and women (*quote Rani et al, 2004, p. 116)*.*

Kvam and Braathen (2008) conducted a study on violence and abuse against women with disabilities in Malawi, and found that the most common type of abuse experienced by that group of women was what they themselves referred to as sexual abuse; men seduced them and told them that they were going to marry them, but when the women fell pregnant, the men left, and the women ended up as single mothers. Furthermore, some of the women said that more and more people in Malawi use drugs and alcohol, and when men do this they often become aggressive and violent. The women stressed the importance of being self sufficient (education and job) in the attempt to empower and bring more respect to women. This included men respecting women, as well as women learning to respect themselves and each other (Kvam & Braathen 2008).

4 Methodology

Data collection for this pilot study on substance use and gender based violence in Malawi was conducted simulatiously with a second study (pilot project 1- See introduction chapter) on substance use and abuse in a Malawian context. The methods used to collect data for the two projects were similar, and somewhat overlapping. Data collection took place over a three week period in November 2007.

The projects have been designed as pilots and, as they are the first of their kind in Malawi, an exploratory design was adopted. Qualitative research methods are exploratory by nature, and were therefore deemed suitable for these, initial, pilot studies. Limited anthropological fieldworks was carried out with the aim of talking to relevant people and visiting relevant places and sites. Within an explorative methodological design the choice of specific research methods in the two studies has been made during thecourse of the fieldwork, depending on the best venue and setting according to the respondents, the interview, the situation, and the study sites (Morse & Richards 2002, Chapter 5). The methods used in the studies were;

- ***Individual interviews***: Semi-structured, interactive interviews following an interview-topic guide but with the emphasis on openly and freely told stories by the informants. The informants led the interview as far as possible, but within certain pre-defined areas of interest.
- ***Unstructured conversations***: The topics were related to the research questions, but were arranged more like informal conversations.
- ***Observation***: The fieldwork was carried out by a Norwegian researcher, and two local research assistants from Malawi. For studies like these it is important that the people who analyse the results, have good knowledge of the study sites, and have taken an active part in the data collection. This is because of the importance of observations made in the field; of the study sites and area, of the informants, etc. Extensive fieldnotes were taken during the the fieldwork.

Interview instruments for this project (Pilot prject 2) focused on men's use and abuse of substances, but more specifically on how this has an affect on women, and how men's drinking or using other substances may lead to various forms of

gender based violence. We asked for women's personal experiences and views, as well as knowledge about other people's experiences and views. Detailed interview guide below (Appendix, chapter 10.2).

Interview instruments for pilot project 1 focused on people's use and abuse of substances both for themselves, their friends, family, neighbours and other people in the village. We asked for people's personal experiences and views, as well as knowledge about other people's experiences and views. Detailed interview guide below (Appendix, chapter 10.1).

To cover both urban and rural aspects, two study sites were selected: For the urban aspects, two Lilongwe townships were chosen; Kawale and Chilinde. For the rural aspect, Chembe village in Cape Maclear, Mangochi District was chosen. (More about the study sites can be found in chapter 5).

4.1 The Research Team

The Norwegian Researcher (Primary Investigator – PI)***;*** Stine Hellum Braathen (Mphil), is a medical anthropologist working for SINTEF Health Research, Norway. The Norwegian researcher is responsible for the overall completion and carrying out of the projects and fieldwork. She has contributed to the development of the methodology for the two projects, trained and supervised the research assistants in the field, taken part in the data collection, analysed the data and written the report.

The Malawian Researcher; Dr. Alister Munthali (PhD), medical anthropologist, is a senior research fellow at the Centre for Social Research (CSR), University of Malawi. Dr. Munthali's role in the projects was to contribute to the development of the research methodology, to identify suitable research assistants, to follow-up the data collection and research assistants and contribute to the report writing.

The research assistants (selected by CSR); Both the research assistants were local Malawians, who speak the most widely spoken language(s) of the study areas, in addition to English. They both have knowledge and experience of conducting this type of fieldwork (as research assistants) from previous projects conducted by CSR. Both research assistants underwent training for the data collection during week one of the data collection period.

- Male researcher, Mr. Robson Malichi Ghama, was selected to conduct fieldwork in Cape Maclear, and to conduct interviews primarily for pilot project 1.
- Female researcher, Miss Ellen Harazi, was selected to conduct fieldwork in Lilongwe, and to conduct interviews with women, primarily for pilot project 2.

4.2 Informants

For this project (pilot project 2) the informants were married women above 18 years of age. For the purpose of this pilot project the scope was limited to women aged 18 years or older. We did, however, talk to these women about their childhood and adolescent experiences in order to gain some insight into the experience of growing up in a setting where substance abuse is common. In finding the informants we asked for women who were wives of men who use substances.

For pilot project 1 the informants were individuals over 18 years of age in the following categories:

- Village headmen/Chiefs
- Customers in local pubs/bars
- People in the villages/markets/meeting places in the villages
- Homes: members of households
- Women who make locally brewed alcohol
- People who grow/sell chamba
- Authority/Government/NGO people working in the field of alcohol/drug prevention in Malawi

The informants were selected through a snowball method, where we approached the village headmen/chiefs first, and they assisted us in finding informants. Then, the informants helped us find other suitable informants. We were present in the study sites over a period of time, and so some informants were also recruited through informal conversations with us.

4.3 Data Collection

Fieldwork for the two pilot projects was carried out simultaneously. The fieldwork was carried out in two phases. In the first part of the fieldwork the PI and the two research assistants were in the field together. This was the phase where the PI trained the two

research assistants in the particular methodologies to be used in the field.

In the second part of the research the local male reseach assistant stayed in Cape Maclear and conducted fieldwork primarily for pilot project 1. At the same time the female research assistant went to the study site in Lilongwe and conducted fieldwork there, primarily for pilot project 2. The PI moved between the two study sites.

4.4 Ethical Considerations

Measures were taken in the two pilot studies to ensure ethical integrity. All participation was voluntary, and the informants were free to withdraw at any time. The informants will remain anonymous during and after completion of the pilot project(s). The information above was given to the informants before the interviews (orally and through a participant information sheet, see appendix, chapter 10.3), and their consent was required before they were interviewed (Informed consent sheet, appendixm chapter 10.4). This information was available in both English and Chichewa.

The real names of the informants will not be documented in any of the written material from the data collection. If the interviews were tape-recorded, the records were deleted as soon as the interviews had been transcribed.

If, in any of the conversations, a woman disclosed experiences of violence or abuse, she was given information about where she could go for help.

The projects were reported to the Norwegian Committee for Research in Social and Human Sciences, and to the National Research Council of Malawi for ethical clearance and advice. Both instances have recommended the projects.

5 Study Sites

Two study sites were selected in discussion with the local partners in Malawi. It was important to cover both urban and rural aspects and so Lilongwe and Cape Maclear (close to Monkey Bay), in central Malawi, were selected (circled on map)[1].

[1] Map downloaded from: http://www.worldtravelguide.net/country/map.ehtml?o=158&NAV_guide_class=&NAV_Region=&NAV_SubRegion=)

5.1 Urban Site: Lilongwe[2]

Lilongwe is the capital of Malawi, with an estimated population of 597 619 (2003 census). It lies in the country's central region, on the Lilongwe River. In 1974, the capital of the country was formally moved from Zomba (the fourth largest city today in Malawi) to Lilongwe. Although, Lilongwe is the official capital of Malawi and has grown immensely since 1974, most commercial activity takes place in Malawi's largest city; Blantyre. Recently, as part of political restructuring, the parliament has been shifted to Lilongwe and all parliament members are required to spend time in the new capital. Lilongwe is now the political centre of Malawi, but Blantyre remains the economic capital (information from www.wikipedia.org).

Kawale is a township in the city of Lilongwe. The township lies between the old town and the newer Capitol Hill/city centre area. There are a number of chiefs in Kawale, and there is a traditional authority that looks after all the chiefs. We met two chiefs in Kawale, both elderly men, chiefs of one village 'block' each.

One of the chiefs had lived in Kawale since 1973, so he knew the area well. He said that Kawale has too many people, but he does

[2] Map downloaded from http://zambia.maruien.com/malawi/lilongwe_map01.gif

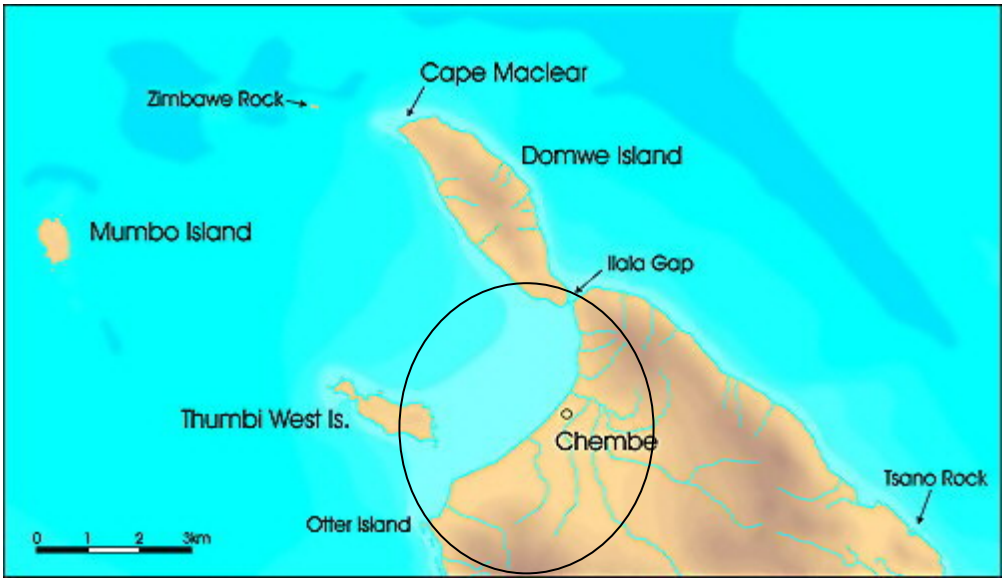
not know how many. There are some rich people, and some who are like himself; not rich, but not extremely poor. By rich, he means people who have a good house with burnt bricks, cars and some business. Poor people, on the other hand, have no chair for visitors, live in small houses, eg, made from un-burnt bricks and with little furniture inside, no personal garden where they can grow things and no fence around their house.

In Kawale, there was a big problem finding informants, as very few people wanted to participate in the study voluntarily. They only wanted to be informants if we could pay them an allowance to attend the interview. Unfortunately, in studies like this, it is unethical and wrong to pay informants to be interviewed; informants have to volunteer to be interviewed, not be paid. The chief said that international NGOs come to Kawale all the time to talk to people, and they all pay people, and give them something to drink to attend interviews, meetings, workshops, etc. People would expect the same from us.

Because of the problems finding informants in Kawale, we decided to move to another township in Lilongwe and search for informants there. We went to Chilinde, the neighboring township to Kawale. We spoke to the chief of an area in Chilinde with approximately 200 inhabitants.

It turned out to be much easier to find informants in Chilinde.

5.2 Rural site: Chembe Fishing Village[3]



Cape Maclear is in Mangochi district, and Chembe fishing village is located on Cape Maclear, along the shores of Lake Malawi. In the lake, just outside of the village, lie the three islands Domwe, Thumbi and Mumbo. The islands and part of Chembe village belong to Lake Malawi National Park. Lake Malawi National Park was established in 1980, and became a world heritage site in 1984. Before the establishment of the national park many people had settled on the islands of Domwe and Mumbo, where they were growing maize and cassava, as well as drying fish. After the national park was established, no-one was allowed to live on the islands, only concessionary businesses like a small (Kayak Africa) lodge was allowed on the islands. Most of the people living on the islands then moved to Chembe village.

Chembe is the largest fishing village in Malawi, with a total size of 8 square kilometers. There are a number of (10-12) lodges in Chembe, mainly catering for foreigners. In addition, there are guesthouses for foreign NGOs working in the area (2-3). There is a lot of tourism in Chembe (compared to the rest of Malawi). The village has beautiful beaches, good snorkeling, and is surrounded by beautiful nature. Boatmen (referred to as beach boys) take people on their boats, woodcarvers sell their produce to foreigners,

[3] Map downloaded from
http://www.cichlidpress.com/safari/malawi/maps/localities/malawi-cape.htm

and there is some work for the locals in the lodges where foreigners come and leave their money. Chembe village is a largely Chewa-tribe dominated community. In 1880, there were about 590 people in Chembe, whereas today there are more than 12 000 people in the village (Information from the Lake Malawi National Park museum).

The highest authority in Chembe is the 'group village' head. The group village head is a traditional authority who is paid by the government. The group village head in Chembe reports to other chiefs (who are higher up in the chief hierarchy) in Mangochi district. The group village head in Chembe, at the time of this study, was a woman. She was filling in for the actual group village head who was her brother, because he had moved to Lilongwe for a while.

The group village head told us that Chembe has 1778 households, with approximately 13 000 people. People mainly fish and grow maize, and there are about 80 tour guides. The soil in Chembe is not very good quality, and sometimes it dries up because there are no irrigation systems in place here. About 6-7 people in the village are regarded as rich, while the rest are seen as poor. Someone who is rich has money to buy fertilizer, employs people to assist in the garden, have fishing-nets, and a house with an iron roof. A poor person has a grass-thatched house that leaks when it is raining, no food, relies on selling bangles (bracelets/ necklaces/ earrings), has poor tattered clothes and cannot send his or her children to schools better than the local ones.

There is a primary school (standard 1-8) in Chembe, and one community secondary school (form 1-4) with forms one and two. If children want to continue with form 3 and 4, they have to go to Monkey Bay. The EU has built more blocks in the community school, but there are no teachers here to teach forms 3 and 4. The local schools are good, but there is status connected to sending your children to private schools. Most children go to school in Chembe, but there are some who don’t go to school at all, and some who go to private schools other places.

There is a small police unit in Chembe, with three rotating employees.

6 Results

The story of Chimwemwe[4]

Chimwemwe is a 24 year old woman living in a township in Lilongwe. When she was 19 years old, Moses; a man much older than her, had come to her village (outside of Lilongwe) and offered to take her to Lilongwe and get her a job in a supermarket during the holiday. The agreement was that she was going to make some money, and he was going to bring her back to the village after the holiday, so that she could continue her education (form 3). When they arrived in Lilongwe he told her that he had lied; that he did not intend to get her a job, but he was intending to marry her. She did not want to marry him, because she was in love with another man, but she did not know how to get away from Moses and away from Lilongwe. *'I used to cry all day'*, Chimwemwe said. One night Moses raped her, and she became pregnant. Not knowing what to do, she turned to the other women in the township for advice, and they encouraged her to accept the situation and to marry him. Today they have been married for four years and they have two children together. Chimwemwe says that her husband is a very jealous man, and he drinks alcohol every day. When he drinks he almost always beats her; *'A week cannot pass without beating me'*. He spends much of the family's income on alcohol, money Chimwemwe feels could be used on much more useful things. Every night Moses comes home drunk, and he urinates and vomits in the bed, and when she tells him to go outside he beats her. He also beats her if she is not wearing a chitenje (sarong), and when her four year old daughter sees her without the chitenje she says, *'Mommy, dad will beat you because he wants you to wear chitenje always.'* She does not like to sleep with her husband when he is drunk, because he stinks, he behaves badly, and she is afraid that he has been cheating on her with other women who may be HIV positive. If she refuses to have sex with him, he forces her. She often talks to other women in the township who also have husbands who drink all the time. There are many of these women where she lives, and the women share many of the same experiences. Chimwemwe says that;

> *'We women are so vulnerable because whenever they* (the men) *are drunk they beat us and they insult, which is not good. We want to be loved.'*

[4] Chimwemwe is not her real name, and her husband's real name is not Moses.

6.1 Informants

The informants in the two pilot projects were chiefs (village head) from Chembe, Kawale and Chilinde, as well as men from Chembe and Kawale, married women from Chembe, Kawale and Chilinde, prostitutes (bargirls) from Chembe and women who brew Kachasu from Chembe and Chilinde.

	Rural setting	Urban setting		
	Chembe	Kawale	Chilinde	**Total**
Chiefs/ Village heads	1	2	1	4
Men	16	1		17
Women	2	1	9	12
Bar Girls	2			2
Kachasu brewers	1		1*	2
Total	22	4	10	36

(*The informant was interviewed both as a Kachasu brewer, as a woman who drinks and as a woman married to a man who drinks.)

Furthermore a number of informal conversations with locals and foreigners (expatriates) in both Chembe and the townships in Lilongwe were held, in addition to informal conversations and meetings with people from the Malawian government and relevant NGOs. All informants were 18 years or older.

All the 17 men, the two bargirls and the chiefs had some education, ranging from primary school standard 2 to completed secondary school, but none of them had higher education. Among the 12 women five had some primary education, 4 had completed form two of secondary education, while 3 had never gone to school. One of the Kachasu brewers did not have any education, while the other had finished primary school.

Among the men, three were married, two divorced, and six had children. The two bargirls interviewed in Chembe both had children, one was divorced and the other had never been married. All the women interviewed were married and had children.

The male informants all said that they had a job; most were tour guides (beach boys) or fishermen, some were souvenir/jewelry-makers, watchmen, one scuba diving instructor, one gardener and one was completing form 4 at the time of the interview. The two married women interviewed in Chembe were both housewives, and

so were five of the women in Lilongwe. Four of the women from Lilongwe were business women (making charcoal, etc.), and two of the women (one from Kawale and one from Chilinde) were Kachasu brewers. In the families where the woman brews Kachasu, she is the main breadwinner of the family. This is unlike most other families in Malawi, where the man is usually the breadwinner.

The main informants in this project were two married women from Chembe, one from Kawale and nine from Chilinde (all married to men who use substances). Some information has, however, been used from interviews with 16 men from Chembe and one from Kawale, two bargirls from Chembe, two women who brew Kachasu (one from Chembe and one from Chilinde), and one informal conversation with a woman who works at a clinic in Chembe.

6.2 Men's use of substances and the affect on their wives and their families

The story of Chimwemwe, at the start of chapter 6, sums up many of the problems women in Malawi face in their relationships with men, and, in particular, men who use substances. Chimwemwe is not the only woman in Malawi with such experiences. Many of the women interviewed in this study struggle with husbands who become violent and irrational when they drink and/or smoke chamba. The women are loyal to their husbands and do their best to be good wives and in that way discourage their husbands from drinking/smoking and being unfaithful, irrational and violent. For example one woman (31) in Lilongwe said that she often discusses with her friends how they can be good wives. She said that,

> *'We teach each other how to cook delicious meals for our husbands so we can attract them with food and not going out for drinking.'*

Her husband drinks every day, and it affects her very much.

> *'His drinking affects me a lot, though he supports the family, but I am a Christian and beer drinking is not allowed in our church. He doesn't pray or go to church, what he knows is drinking. When he's drunk, he talks much and I didn't like it and he insults other people too. (…) He used to beat me, but he stopped.'*

Similarly, another woman (20, Chembe) does not like it when her husband drinks;

> *'I don't like it because when he gets drunk he becomes so talkative, and he loses some of his senses and it stinks a lot.'*

A man (30) from Chembe knew that men's drinking was a problem to their women;

> '*The bad side of beer is that it affects people who are not drinking with you; like the wife is not happy to see her husband drunk. This brings poverty in the house.'*

Some of the women said that they were worried about their husband's health because of their excessive drinking and smoking chamba. They were afraid that the substance use would spoil their husband's health, or even kill them.

> *'…men are dying because of drinking Kachasu. Kachasu is dangerous when drinking without food. It spoils your lungs and you eventually die'* (Woman, 28, Chembe).

All the women said that they knew of men who drink, and these men are often violent when they are drunk. They become aggressive from the alcohol, and often come home arguing with their wives, sometimes beating them and forcing the women to have sex with them. Some even knew of men who beat and rape their own children or other children. The next day the men would then say that what they did was not on purpose, but because they had been drunk, and did not know what they were doing.

One male respondent (25) from Chembe said that he sees that beer drinking has a big impact on families in Cape Maclear, because most husbands spend most of their time drinking beer. At night they are in the lake fishing and during the day they are in pubs drinking.

> *'Their women feel neglected and most of them just surrender to break up the family. Most families have ended because of their husbands' drinking heavily, and forgetting to support the family.'*

Men, when they are drunk, often do things and behave in ways they wouldn't if they were sober. One man (30) from Chembe said that there was a day when he quarrelled with his wife because he was drunk. He left his home the same night and went to his parents. When he woke up in the night he realised that he had made a mistake and he did it because he was drunk, and therefore he went back to his house.

A woman (20) from Chembe felt that men's use of substances led to nothing but despair, and wished that the men would stop drinking;

> *'I know my husband spends a lot of money on beer though I don't know the exact sum. (…) It's our plea, my plea that they should stop drinking because there's nothing they get in those substances apart from ruining families. And these women too, they should stop brewing the beer (Kachasu) because it's cheap and many people go there to drink unlike in bars where the beer is expensive'.*

A 61 year old woman from Lilongwe said that she drinks every day;

> *'I drink every day, any time and where they sell Kachasu. (…) If I am not drunk I think a lot about my children who passed away and how poor we are, so I am forced to drink every day.'*

Furthermore she said that her (grown) children do not like it that she drinks, but she can not stop because of that;

> *'…When I am drunk I sleep along the road and my children don't like it and they always advise me to stop drinking, but I just can't; my body is used to beer, and when I am not drunk I feel like I am missing.'*

One woman (28, Lilongwe) said that her husband, when he drinks, *'he doesn't think properly, he beats our children, and when eating he wants more relish, and when I say we don't have enough relish, he shouts at me, and I am not happy with his behaviour. I want him to change. (…) When men drink they themselves become happy, but we women are not happy, and I always tell my husband to stop this drinking.'*

When the women tell their husbands to stop drinking it has little or no effect on the men. One man said that he can not stop drinking because his wife tells him to, because his friends may think that he listens to his wife, and then he is not a proper man. The only reason he would consider stopping would be if the doctor told him to or if he wanted to go back to church again (as his church does not approve of drinking). One woman (27, Lilongwe) said that when she asked her husband to stop drinking he said that;

> *'Unandipeza ndikumwa'* (You found me drinking, so who are you to tell me to stop?).

The women are pleading with their men to stop using substances and to start being responsible for their families.

> *'Men, change! You are ruining your families!'* (Woman, 28, Lilongwe)

6.3 Economy of the family and irresponsible husbands

> *'Had it been that he doesn't drink we could have always have enough food…'* (Woman, 27, Lilongwe).

When men who are married and have children drink and smoke chamba it has an enormous affect on the economy of the family. All the married women interviewed in this study were frustrated because their husbands spent so much of the family's much needed money on alcohol, drugs and bargirls. The women felt that this money could have been put to much better use buying food and clothes, and making sure that they had enough money to put their children through school.

> *'The money he uses on beer, drinking and smoking; we can use it on useful things here at home, but he just can't listen. So it's my request to you all who drink and forget your families to stop drinking and take care of your families'* (Woman, 24, Lilongwe).

> *'We are sleeping without food because of your drinking'* (Woman, 26, Lilongwe).

All the women said that men who drink are not responsible for their families. By this they mean that the men are always out drinking, and although they are supposed to be the breadwinners of the family, they spend most of the family's income on alcohol.

> *'…the money he spends on boozing we can use it on useful things'* (Woman, 28, Chembe).

A man (24, Chembe) who drinks himself said that whenever he is drunk his thinking level goes up, and he becomes intelligent. The bad side of his beer-drinking is that he spends a lot of money buying beers

> *'(…) and you can not prosper with beer. A lot of people have become useless in the community because of drinking beer. They make a lot of money today, they go drinking and all the money is being used up at the pub leaving wife and children suffering.'*

Furthermore; men, when they drink, get very hungry, and when they come home they want to have food on the table, but often there is no food, because they have spent all the money on alcohol that should have been spent on food. This leads to a great deal of

anger and frustration in the drunken man, and he often ends up shouting at his wife, or even worse; beating her.

> *I am a bread winner here because my husband is not responsible for the family. What he knows is drinking, and I am the one who looks after whatever we have. My husband goes to drinking in the morning and comes home at night daily. (…) The money I find in* (my job) *is not enough for the household. I have to pay school fees for my children and buy food. (…) He drinks every day, and he doesn't give me any money. When he comes home he wants something to eat, (…) and he quarrels if he doesn't want the type of relish we have prepared. He does not eat nsima, only relish. I am not happy with his behaviour' (Woman, 40, Lilongwe).*

Another woman (26, Lilongwe) had similar experiences;

> *'I don't like his behaviour of drinking these substances because we always don't have enough food here at home and we don't have enough clothes too. What he knows is drinking his beers, but when he comes home, he wants something to eat, as if he left the money. (…)This house is not ours, sometimes we don't pay our landlord at the right time it's because of my husband, and I know one day they will chase us from their house. We always quarrel and most of the times he beats me. He insults me and he says I don't qualify to be his wife'.*

6.4 Physical abuse

> *'Men, whenever they are drunk, they insult you and everyone; they become animals when they are drunk'* (Woman, 25, Lilongwe).

Of the 12 married women who were interviewed in this study, five had recently experienced being abused physically by their husbands, and one used to be abused, but the husband had stopped. In all the cases the men had been drunk. The five women who had recently been abused experienced this type of abuse regularly in their marriage. All the 12 women knew of women who were abused regularly because their husbands were drunk.

> *Because of his excessive drinking I always think of going home but we have no house at home, unlike here - it's our house though we are struggling. He's not responsible at home, but when he comes home he insults me, beats me and he insults other people as well. I always pray to my God that he should change his behaviour.*

One woman said that she often asks her husband why he drinks, when it is so bad for his family.

(…) When I ask him why he drinks he say he wants to be happy and he forgets his problems. But then I tell him that he's selfish, because he can't be happy while his family is not happy. There are also other men who beat their wives as well. We women we are not happy with our husbands, they take us for granted maybe because we are not working, they don't buy food and they don't buy us clothes' (Woman, 43, Lilongwe).

Another woman (25, Lilongwe) had similar experiences with her husband;

'When he's drunk, he becomes mad, he talks at the top of his voice, he beats me and he eats all the relish in the pot, which is not good. I am like a slave to him. I am not happy at all. I don't enjoy marriage because we have no food, he spends his money on drinking and he comes home late'.

One man insults, and is violent to strangers, friends and his family;

'When he's drunk, you can't like him, he insults everybody he sees, including me who washes his uniform, who cooks for him. I feel always embarrassed with this man. I am regretting why I married him, he is a useless man. He goes to work leaving me with nothing, but he comes home drunk, he doesn't love me at all' (Woman, 27, Lilongwe).

One woman (61, Lilongwe) who drinks alcohol herself said that;

'Most people who use substances they are not responsible for their families. Of course there are some who take care of their families, but most of them don't, and some they also insult people and even beat up the wife as well. And personally I have seen them fighting or abusing their wives, and sometimes they are also sexually abused. These men also rape other women and children.'

In Chembe there is a clinic, which is run by an Irish foundation. The clinic has been there for eight years, and the founder of the clinic has noticed a change in Chembe over those eight years. She said that there has been a dramatic increase in the drinking in the past 3-4 years, while her impression is that the use of chamba has decreased. She has also seen an increase in prostitution in the village, and there are more bars and Kachasu places than before. At the clinic there has been an increase in women coming there with burns, sores, wounds, etc. from domestic violence.

The women complain about the men who drink and smoke, and the men themselves often realize that they are a problem to the women, but it is not a realization that will make them stop using

the substances that are causing the problems. One man (28) from Chembe explained that;

> *'Alcohol makes…you be like a crazy man, and you need to control yourself, and if you don't have good head to control yourself you go at your wife.'*

He further explained that if he has been drinking all day and spent all the family's money on alcohol, and he comes home telling his wife to bring food, and there is no food, because there was no money, because he spent it all, he gets angry at his wife.

Another man (30, Chembe) said that whenever he smokes chamba he becomes violent and aggressive, and he argues and fights with his wife and his friends. Now he has stopped smoking chamba.

Most of the people selling and brewing Kachasu are women. One of the women (38) selling in Lilongwe said that she often experiences men getting aggressive and violent after drinking Kachasu.

> *'Through this business I have faced lots of problems. Some they insult me after drinking my beer and doesn't want to pay me my money, most of the times I quarrel with them and some they say they will beat me.'*

A bargirl (18) from Chembe said that the work she does is not good at all because it makes her suffer *'(…) because you have to remain drinking in order for you to suit the environment, (…) in order to get money and sometimes we are beaten by men.'*

6.5 Sexual abuse

Seven of the 12 married women who were interviewed in this study had experienced being raped (forced to have sex) by their husbands, and 11 of them knew of other women who had been sexually abused by their husbands or other men who had been drinking alcohol or smoking chamba. The rape could potentially have implications beyond the dramatic experience of being raped. Many of the women suspected or knew that their husbands were unfaithful to them when they were out drinking, and the wives were worried that the women their husbands were unfaithful with (often bargirls) would be HIV positive. This was a big concern to many of the women, because if the men become HIV positive it is likely that the women would catch the disease also, which in the long run leaves their children orphaned. As one woman said,

> *'My husband drinks a lot, so I am afraid that he might catch the disease and infect me'* (Woman, 20, Chembe).

Women commonly talk about how they can be attractive to their husbands, to avoid the men being unfaithful to them,

> *'We tell each other to take care of ourselves, because if we don't look smart we will lose our husbands. But we have to be always smart, or they will start having other affairs'* (Woman, 27, Lilongwe).

But usually to little or no avail;

> *'…men who use these substances change their behaviour. Some they start sleeping with bargirls, which is bad because they can contract STDs* (sexually transmitted diseases). *(…) I am saying this because I have seen it. A man transmitted a sexual disease because he was drinking too much and slept with bargirls, and when they are drunk they have no respect (…)* (Woman, 28, Chembe).

A young woman (20) from Chembe said that because she had just given birth, she had not had sex with her husband for many months, but now she was afraid that he would want to have sex with her again. They had both tested negative to HIV while she was pregnant, but since then she thought that he had been unfaithful, so she had asked him to get tested again, but he refused. When they were still having sex (before the pregnancy), he had often forced her to have sex with him, and she was afraid that he would force her again. Her husband usually forces her to have sex when he has been drinking, and he was not the only man who has forced his wife to have sex with him when he was drunk or high.

> *'I am afraid to go and do an HIV test because I know he has affairs, and maybe he has affected me with the virus. And he has forced me to sleep with him sometimes. I know it's because he has no feelings maybe for me because he has another affair'* (Woman, 40, Lilongwe).

7 Discussion

The Malawi Demographics and Health Survey (DHS 2005) showed that women who are married to men who drink are more likely to report physical abuse compared to women married to men who do not drink. This study has attempted to go into detail on the consequences of men's drinking to women (their wives in particular). The results from this study (as well as pilot project 1) have shown that men's use of substances have many implications for the men themselves, for their families, their friends, for the community in which they live, for society as a whole, and potentially also for the development of Malawi as a country. The implications are especially serious for the wives and children of the men who use substances.

A previous study by Rani et al (2004) showed that men in Malawi (compared to other countries in Africa) were less likely to justify wife-beating than women. This is an interesting finding, and a trend which can also be found in this study from Malawi. In the story of Chimwemwe (Chapter 6, page 18) we see that she is advised by the other women in the village to simply accept the situation and learn to live with it when she has been raped and made pregnant by her rapist. Furthermore, she is advised to marry the man and live with him, because he is after all the father of her child. The results also show that the women take the responsibility upon themselves to make sure that their husbands do not drink or have sex with other women. The women do their best to be attractive to their men and make their homes and the food attractive so that the men will come home instead of going out drinking and possibly having sex with other women. Some of the men who drink said that they realize that in doing so they are inflicting pain and frustration on their wives and their children. They know that this is bad, and should not be accepted, but they find it very hard to stop drinking.

This study has found three main types of abuse as experienced by many of the female informants, and known of by all of the informants, women as well as men:

- Economic abuse
- Physical abuse
- Sexual abuse

7.1 Economic abuse

Most women in Malawi, and most of the women in this study, depend on their husbands to bring money to the family, in order to buy food, clothes, etc. What this study has shown is that the men who use substances (most commonly alcohol) are often unable to provide their families with the basic necessities, because they spend so much of their income on alcohol. As a result women and children go hungry, with tattered clothes, and children/young people are sometimes unable to finish their education because of a lack of money. Some of the women in Lilongwe had started businesses of their own (selling charcoal, nuts, etc.), so that they could make their own money and not be dependent on their husbands. This may be a good way of empowering the women, and encouraging the men to look after their families, as was stressed by the women in the study by Kvam and Braathen (2008). Women feel better about themselves and more secure knowing that they can look after themselves, and men may appreciate and respect women more if the women are not completely dependent on them for their own and their children's survival.

7.2 Physical abuse

Men often get aggressive and irrational when they drink alcohol or smoke chamba, and this can lead to bad behaviour. In both Lilongwe and Chembe people reported seeing drunk or stoned men fighting and arguing with other people in the community, but most often they go home to their wives and end up taking their anger out on them. The results show that it is not uncommon for women who are married to men who drink and/or smoke to be beaten up or yelled at. This corresponds with findings from the previous studies in Malawi (Pelser et al 2005 and DHS 2005), stating that men's use of alcohol puts their wives at risk of physical abuse. We also see from our study that there is a connection between the economic abuse and the physical abuse experienced by women. Some men are unable to give their wives money for food (because they have spent it all on alcohol or drugs), and when they come home drunk or stoned and hungry, there is no food on the table and they get angry, and beat their wives for not preparing food for them.

7.3 Sexual abuse

The sexual abuse, as experienced by many of the women in this study, has been referred to as rape throughout this report. The women themselves, however, did not call it rape, or even abuse. The reason for this may be that the most common abuse is what happens between a husband and a wife, when he gets home drunk or stoned, and he wants to, and feel he has the right to have sex with his wife. The wife, on the other hand, does not want to have sex with her drunken or stoned husband who behaves strangely or badly and smells. She may also be afraid that he has been having sex with other women who may be HIV positive. When she refuses sex he forces her; and that is what is referred to as rape in this report, what is referred to as 'his right' by the men, and what the women also seem to see as the men's right, although they do not like it themselves. According to the men, it is true that men often cheat on their wives when they are out drinking, and they often have sex with bargirls (prostitutes). There is a good chance that the bargirls are HIV positive, and that the will men catch the virus from them, and be in a position to infect their wives with the virus as well. This was a big worry to many of the female informants in this study.

This kind of sexual abuse was the most common form of abuse experienced by the women in this study, while previous studies in Malawi have not highlighted sexual abuse as very common (not mentioned in the DHS (2005), and less than 18% reported sexual abuse in the study by Pelser et al (2005)). As the study by Kvam and Braathen (2008) showed; it is important to expand the definition of sexual abuse to mean more than the 'traditional rape' (usually thought of as acts of severe violence and force). Rape or sexual abuse can be any act which is against the will, or out of the control of the victim (such as tricking (as in Kvam & Braathen 2008), cheating and force).

8 Conclusions

This study highlights the importance of addressing the impact on women when men use substances. The results indicate that there is a strong connection between men's use of substances and gender based violence. In an attempt to minimize the affect on women it is important not just to look at how to reduce men's use of substances, but also to look at how to empower women. Several studies from Malawi indicate that Malawian women have a lack of respect for themselves and other women, and that men also share this disrespect for women. Women must learn how to be self sufficient and also to appreciate and be appreciated for the important contribution that they make to the family, to the community and to Malawian society as a whole.

Based on the results from this study a few conclusions and future recommendations can be drawn;

- Empower women through education and jobs, to enable them to be self sufficient and not dependent on their husbands for survival (to increase men's respect for women and women's respect for themselves)
- Increased focus, through research and government priorities, on wives' being sexually abused by their husbands and how this may contribute to the spread of HIV/ AIDS in Malawi
- Increased focus on sexual abuse, cheating, prostitution in relation to substance use, and how this relates to the spread of HIV/ AIDS in Malawi
- Increased focus on women's rights
- Increased focus and awareness on alcohol and drug use and how this affects women, children and families in Malawi

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10 Appendices

10.1 Interview Guide Men

Thank you!

Thank you very much for agreeing to talk to us. We appreciate your willingness and generosity to make time to talk to us. Your stories, opinions, experiences and thoughts are of great importance and value for the results of the study that we are doing.

Presentation of researchers and the study

First of all we/I would like to present ourselves/myself and the study we are doing.

This study is initiated by FORUT (Norway) and NGO gender coordination network, and will be carried out by researchers from SINTEF Health Research (Norway) and the University of Malawi. We want to learn from you about your experiences, knowledge and thoughts with regards to the use of substances. We want to talk to both women and men in the study. The information that we collect in this study will be useful for FORUT, NGO gender coordination network, government departments, and more.

We are/I am going to ask you about your childhood, youth and about your adult life/life today.

You may find some questions difficult to answer, or you may not want to answer them. You are, of course, fully entitled to refuse to answer any questions you don't want to answer. You may also - at any time - say that you want to stop the interview, and we/I will respect your decision.

We/I will ask for your permission to tape-record the interview. We/I only do this in order to take more extensive notes from the interview. The recorded interview will be deleted after notes have been taken/interview has been transcribed, and will not under any circumstances be taken out of Malawi or used for any commercial purposes. You may refuse to allow the interview to be tape-recorded.

Remember also that everything you tell us/me will be kept anonymous. Your name will not be used in our papers and reports, or for any other purposes, and it will not be possible to trace the answers you give back to your name and your person. Your name

will not be written down anywhere in the interview notes, in the report or in articles to be written.

Do you have anything you want to say or any questions before we start the interview?

The Interview

1. Demographics informant and his family
    a. Informant
        i. Area of residence
        ii. Urban/Rural
        iii. Age/year born
        iv. Tribal group
        v. Religion
        vi. Education
        vii. Job
    b. Parents
        i. Parents alive
        ii. Parents education
        iii. Parents job
        iv. Where do they live
    c. Sisters/ brothers
        i. Job of sisters/brothers
        ii. Education of sisters/ brothers
        iii. Where do they live
    d. Marital status
        i. How many wives
        ii. Wife education
        iii. Wife job
        iv. Number of times married
        v. Number of times divorced
    e. Children (number of living children/same mother/how many mothers?)
        i. Children age
        ii. Children education
        iii. Children job
        iv. Children married
        v. Grandchildren

2. Living arrangements/life
    a. Who do you currently live with?
    b. How are daily chores divided in the household (who does what?)?
    c. Who makes the earnings in the family?
    d. Who has control of the economy in the family?

e. What do you do during an average day in your life?
f. Do you have many friends?
g. What do you normally do when you are with your friends?
h. What do you normally do when you are with your family?

3. Personal substance use (ask the questions that are relevant)
   a. Do you use any substances such as alcohol, tobacco, chamba, etc? What do you use? (alcohol – Carlsberg, other similar products? Spirits? Homebrews – spirit or beer? Chamba – (imported or grown in the area?) other drugs? (types, price, local names, etc))
   b. How often do you use the different substances?
   c. How much do you normally use when you use substances?
   d. When do you normally use substances (morning/lunch/evening/night, on special occasions, rituals, during the week/weekends, etc)?
   e. Who are you usually with when you use substances?
   f. Are there any people you would *not* use substances when you are together with?
   g. Where are you (at home, market, bar, friend's house, etc.) usually when you use substances?
   h. How old were you when you first started using substances?
   i. How do substances (the ones you use) affect you?
   j. Why do you use the substances you use? (change mood/escape sober reality/to fit in a social setting/social and symbolic value of drinking)
   k. Proportion of daily household budget that goes to alcohol and drugs? Do you have to give up other things in order to afford substances?
   l. Do you ever do things when you are drunk that you shouldn't do/that you regret? (Privileges of being drunk: can do stupid things and get away with it because he was drunk) Do you know other people who do this?
   m. What kind of reactions do you meet from other people/do you have with regards to stupid or bad things you or others may do when you or they are drunk?
   n. Do you consider yourself to have a problem with the use of substances?
   o. If yes, have you sought help with your problem? What kind of help would you want or have you got?

4. Other People's substance use/Society/culture
    a. Who commonly uses substances in your village/town (subgroups)?
    b. How old are children or young people normally when they start using substances today?
    c. What kinds of substances are commonly used in your village/town/area of residence?
    d. Where do people in your village/town usually consume substances?
    e. What is the availability of substances in your village/town like? (who sells? Where? Price?)
    f. How are substances grown/imported/brewed?
    g. Is it commonly accepted that people use substances?
    h. Is it legal to use substances?
    i. Is it common to use substances in relation to traditional beliefs and rites? (rituals connected to different substances (weddings/funerals/childbirth, etc))
    j. Is it common for both men and women (boys and girls) to use substances?
    k. How, in your experience, do substances affect other people?
    l. How is the use/abuse of substances looked upon in society? To what degree is it tolerated? Encouraged? Respected? Shunned?
    m. Are there social settings where it is unacceptable/acceptable to use substances? (work, at home, with children, etc…)
    n. Economic status in relation to substance use (can drugs and alcohol be an 'artificial requirement'? Do rich people or poor people use substances?)
    o. Are there any preventive actions against substance abuse and use?
    p. Are there rehabilitation clinics or measures for people with substance abuse problems?
    q. How do you view/do you know of existing substance legislation (for alcohol or drugs)? Views on/awareness of these?
    r. What are the positive sides to people using substances?
    s. What are the negative sides to people using substances?

10.2 Interview Guide Women

Thank you!

Thank you very much for agreeing to talk to us. We appreciate your willingness and generosity to make time to talk to us. Your stories, opinions, experiences and thoughts are of great importance and value for the results of the study that we are doing.

Presentation of researchers and the study

First of all we/I would like to present ourselves/myself and the study we are doing.

This study is initiated by FORUT (Norway) and NGO gender coordination network, and will be carried out by researchers from SINTEF Health Research (Norway) and the University of Malawi. We want to learn from you about your experiences, knowledge and thoughts with regards to the use of substances. We want to talk to both women and men in the study. The information that we collect in this study will be useful for FORUT, NGO gender coordination network, government departments, and more.

We are/I am going to ask you about your childhood, youth and about your adult life/life today. You may find some questions difficult to answer, or you may not want to answer them. You are, of course, fully entitled to refuse to answer any questions you don't want to answer. You may also - at any time - say that you want to stop the interview, and we/I will respect your decision.

We/I will ask for your permission to tape-record the interview. We/I only do this in order to take more extensive notes from the interview. The recorded interview will be deleted after notes have been taken/interview has been transcribed, and will not under any circumstances be taken out of Malawi or used for any commercial purposes. You may refuse to allow the interview to be tape-recorded.

Remember also that everything you tell us/me will be kept anonymous. Your name will not be used in our papers and reports, or for any other purposes, and it will not be possible to trace the answers you give back to your name and your person. Your name will not be written down anywhere in the interview notes, in the report or in articles to be written.

Do you have anything you want to say or any questions before we start the interview?

The Interview

1. Demographics informant and her family
    a. Informant
        i. Area of residence
        ii. Urban/Rural
        iii. Age/year born
        iv. Tribal belonging
        v. Religion
        vi. Education
        vii. Job
    b. Parents
        i. Parents alive
        ii. Parents education
        iii. Parents job
        iv. Where do they live
    c. Sisters/brothers
        i. Job of sisters/brothers
        ii. Education of sisters/brothers
        iii. Where do they live
    d. Marital status
        i. Husband education
        ii. Husband job
        iii. Number of times married
        iv. Number of times divorced
    e. Children (number of living children/same father-how many fathers?)
        i. Children age
        ii. Children education
        iii. Children job
        iv. Children married
        v. Grandchildren

2. Living arrangements/life
    a. Who do you currently live with?
    b. How are daily chores divided in the household (who does what?)?
    c. Who makes the earnings in the family?
    d. Who has control of the economy in the family?
    e. What do you do during an average day in your life?
    f. Do you have many friends?
    g. What do you normally do when you are with your friends?
    h. What do you normally do when you are with your family?

3. Substance use/personal (ask the questions that are relevant)
    a. Do you use any substances such as alcohol, tobacco, chamba, etc? What do you use? (alcohol – Carlsberg, other similar products? Spirits? Homebrews – spirit or beer? Chamba – (imported or grown in the area?) other drugs? (types, price, local names, etc))
    b. How old were you when you first started using substances?
    c. How often do you use the different substances?
    d. When do you normally use substances (morning/lunch/dinner/night, on special occasions, rituals, weekends/weekdays, etc)?
    e. Who are you usually with when you use substances?
    f. Where are you (at home, market, bar, friend's house, etc.) usually when you use substances?
    g. How do substances (the ones you use) affect you?
    h. Proportion of daily household budget that goes to alcohol and drugs? Do you have to give up other things in order to afford substances/ for your family members to afford substances?
    i. Do you ever do things that you shouldn't do/ that you regret when you are drunk? (Privileges of being drunk: can do stupid things and get away with it because she was drunk)
    j. What kind of reactions do you meet from other people with regards to stupid or bad things you do when you are drunk?

4. Husband/ other people's use of substances (ask the questions that are relevant)
    a. Are there people in your family/ friends who use substances? (who)
    b. How do you feel about these people using substances?
    c. How does other people's substance use affect you and your life?
    d. What is your experience with people who use substances – throughout your life?
    e. Who commonly uses substances in your village/town (subgroups)?
    f. What kinds of substances are commonly used in your village/ town/ area of residence?
    g. Where do people in your village/town usually consume substances?
    h. How is the availability of substances in your village/town? (who sells? Where? Price?)

i. Is it commonly accepted to use substances?
j. Is it legal to use substances?
k. Is it common to use substances in relation to traditional beliefs and rites? (rituals connected to different substances- weddings/ funerals/ childbirths, etc)
l. When is it common for people in Malawi to start using substances?
m. Is it common for both men and women (boys and girls) to use substances?
n. Why do you think people use substances? (Why do you use?) (change mood/ escape sober reality/ to fit in a social setting/ social and symbolic value of drinking)
o. How is the use/abuse of substances looked upon in society? To what degree is it tolerated? Encouraged? Respected? Shunned?
p. Are there social settings where it is unacceptable/ acceptable to use substances? (work, at home, with children, etc…)
q. Economic status in relation to substance use (can drugs and alcohol be an 'artificial requirement'?)
r. Are there any preventive actions against substance abuse and use?
s. Are there rehabilitation clinics/ measures for people with substance abuse problems?
t. How do you view/ do you know of existing substance (alcohol/ drugs) legislations: views/ awareness of these?

5. Unwanted behaviour with regards to substance use:
    a. How, in your experience, do substances affect other people?
    b. Have you experienced drunk/drugged people doing things they wouldn't do when they are sober? What do they do? (Privileges of being drunk: can do stupid things and get away with it because she was drunk)
    c. How is this looked upon?
    a. Do you have experience with drunken people/people on drugs being violent (towards you or others)?
    b. How does men's (husbands', fathers', sons', friends', acquaintances') use of substances affect women?
    c. Have you ever heard of/experienced sexual abuse related to men's use of substances?
        i. Has your husband ever had sexual relations with you without your consent? Has this ever had to do with him being under the influence of substances?

   ii. Has your husband ever slept with another woman? Is he/has he been under the influence of substances when this happened? How do you feel about this?

d. Have you ever heard of/experienced physical abuse related to men's use of substances?
   i. Does your husband ever hit you, beat you or strike you, and is he ever under the influence of substances when this happens?
e. Have you ever heard of or experienced psychological abuse related to men's use of substances?
   i. If yes to any of questions c, d and e tell us what happened or happens, how it is looked upon, what do you or the abused woman do, is it reported to the police, etc.
   ii. How have acts of violence impacted on you; when it happened and today?
f. How is the household money spent? Is it ever used on things without your approval, and things that you disapprove of? How? What?
g. How do men's personalities change when they use substances and how does this affect you and/or other women that you know/know of?
h. Are there particular settings or particular types of men that are violent towards or disrespect women?
i. How much money do the men you know spend on substances and how does this affect the household economy?
j. How do you feel about men's drinking/use of substances?
k. Ideally, how would you like things to be with regards to substances?
l. What could be done to make things better?

10.3 Participant Information Sheet

Study on the use of substances in Malawi
Participant Information Sheet

This study is initiated by FORUT (Norway) and NGO gender coordination network (Malawi), and will be carried out by researchers from SINTEF Health Research (Norway) and the University of Malawi. We want to learn from you about your experiences, knowledge and thoughts with regards to the use of substances. We want to talk to both women and men in the study. The information that we collect in this study will be useful for FORUT, NGO gender coordination network, government departments, and more.

We will ask for your permission to tape-record the interview, and to take some notes along the way. You are free to refuse any of these requests without prejudice.

Some of the questions may be too personal, or you may be unable to answer them for other reasons. You are free to answer or not answer whichever questions you like. If you at any point wish to terminate the interview, this will be done without any questions or prejudice. If you at any time wish to withdraw from this study, even after the interview is conducted, you are free to do so. All the information obtained in this interview will be kept confidential, and your name will not be used at any point.

If you have any questions regarding this study please contact Stine Hellum Braathen, ph. +47 982 30 472, e-mail: stine.h.braathen@sintef.no, or Alister Munthali, the Centre for Social Research, University of Malawi, ph. +265 8822004.

Thank you for considering participating in this study.

Principal Investigator
Stine Hellum Braathen
Research Scientist
SINTEF Health Research
Living conditions and Service Delivery

10.4 Informed Consent Sheet

Study on the use of substances in Malawi
Informed Consent

I (the informant) _____ agree to the conditions as stated in the Participant Information Sheet. I am aware of the fact that I am participating in this study on a strictly volunteer basis, and that I can withdraw at any time.

All the information obtained in this interview will be kept anonymous, and can not be traced back to the individual informant. Name and picture of the informants will not be used in public without consent from the informant.

_____
Informant Signature

_____
Researcher Signature

_____
Researcher Signature